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Before the Hearing of the

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

"Betrayal: The Quality of Care in California Nursing Homes"

July 27, 1998

Senator Grassley and Members of the Committee:

Thank you for inviting me to discuss my concerns about the failure of California nursing homes to deliver quality care to our elders.

In 1988, I was hired in my first California nursing home, the day after I arrived from Texas. The nursing facility which hired me did not check my background or even determine if I was licensed in California. I began work there while waiting for the local acute care hospital to complete their reference and background checks of me, as was their practice. During my four months at this nursing home, I witnessed the rape of an elderly woman. I was asked to leave with two weeks pay because I objected to the false manner in which the nursing home documented the rape. I followed the case and assisted in the conviction of a male CNA, who had a history of moving from facility to facility.

In 1991, I took my second job in a private nursing home in Northern California and rose through the ranks from a charge nurse to Director of Staff Development, the number 2 position in the nursing department. I was employed in this particular facility for four years, serving under three administrations, six directors of nursing, and two owners.

Staffing

Because I had previously worked in a skilled nursing facility within a California prison, I was particularly upset about the quality of care in this private facility, especially in regard to staffing issues. For example, the patient to nursing staff ratio in the skilled nursing facility inside the prison was 4 to 1. This ratio does not include the guards in the skilled nursing facility. Compare this staffing ratio to that found in California's private skilled nursing facilities20 to 1.

The skilled facility where I worked for 4 years, was home to 120 residents. It was frequently staffed on night shift with 1 nurse and 2 Certified Nursing Assistants [CNA's] for all 120 patients. On the day shift it was common for the CNA's to be responsible for providing total care, including feeding, bathing, oral care, exercise, repositioning, activities, and social interaction, to 20 or more patients. If they saw a patient one time on their shift the patient was lucky! The most unfortunate dilemma I faced working in this nursing home was knowing how severely the understaffing was affecting the care for the residents, and that temporary agency nursing personnel could and should have been hired. The administration refused to even hear a request for these outside services. Regardless of patient acuity and missing staff, they refused to ensure that sufficient employees were available to care for the residents.

In my experience, neglect and abuse of residents in nursing homes is primarily a function of staffing. Nursing homes are understaffed with unqualified, underpaid and unsupervised nursing personnel. As a

result of this understaffing, patients suffer malnutrition, dehydration, bedsores, urinary tract infections, fractures and loss of limbs from gangrenous bedsores. As we sit here today, there are nursing home patients dying from starvation, dehydration, and sepsis from untreated bedsores, bowel impactions and urinary tract infections.

Weight Loss

Weight loss is an unfortunate, preventable recurring event in California skilled nursing facility. It is primarily due to the understaffing of the skilled nursing facility which leads to residents not being fed or given water. For example, I reviewed the records of an elderly female resident who lost more than one third of her body weight in three months. Due in large part to her severe weight loss, this 78-year-old woman developed three Stage IV bedsores. She had no terminal medical condition, and was ambulatory with assistance upon her admission to the facility. This unfortunate woman died within two weeks of her admission to an acute care hospital from sepsis. I wish this were an isolated incident, but Senator Grassley and Members of the Committee, this is a daily occurrence in California nursing homes.

Falsification of Records

Records in the skilled nursing facility where I was employed were falsified on a daily basis. This was standard operating procedure within the facility. In fact one could say it was policy and procedure under all of three administrations. For example, every month all of the medication administration records would be taken into the Director of Nursing's office, the blinds drawn and the records would be pored over. Any holes in the records would be filled in. In other words, a resident who had not received his medications as prescribed, according to his record, we would fill in the blanks with initials of nursing staff, who may or may not have even been on duty at the time!

The same was done with treatment administration records, weekly nursing summaries, activities of daily living sheets, documents recording dietary intake and output, wound assessment and treatment records, restorative aid records, and last but not least the MDS [Minimum Data Set] and quarterly assessments. Problem patients that were potential for litigation or Department of Health Services scrutiny would receive special attention. These patients' records were often rewritten and totally fabricated with the participation and ratification of the Administration, including the Director of Nursing, Owner and Medical Director. Even when the Administration hired industry consultants to assist in pre-survey preparation, the consultants did not guide us in following state and federal regulations, instead they were more concerned with paper compliance. So every chart was reviewed and ***prepared*** for state survey.

Falsification of records in nursing homes occurs on a daily basis for a variety of reasons, the most common of which is understaffing. The facilities simply do not have enough staff to deliver the necessary care to their residents. Residents are not fed, hydrated or repositioned adequately, and negative outcomes are the result. Chemical and physical restraints are used in lieu of activities and exercise, all for the convenience of the nursing facilities and in many cases for their profits.

The Minimum Data Set

I am a strong believer in the MDS process, however, it is not carried out in the skilled nursing facility, ***and is not enforced by DHS***. In fact, a DHS nurse evaluator who now works as a consultant for the nursing home industry testified in a deposition, in which I participated, that the MDS was "strictly paper compliance," and was in her view unnecessary. Therefore, she was testifying in favor of the nursing home, despite the fact that the MDS in that case did not reflect an accurate assessment or generate an appropriate plan of care for the resident in question. This resident began developing a bedsore within ten

days of admission. This resident was a short term respite care resident, who rightfully should have gone home in the same condition that she arrived. Instead, this resident required three surgeries to remove infected bone and tissue and to replace the skin she lost to the bedsore with skin from another part of her body, all because of the preventable bedsore she developed in the skilled nursing facility where I worked. This elderly woman spent three months post-surgeries immobilized, laying on her stomach. I must emphasize that she had been living on her own as a paraplegic in her own home for more than ten years without any bedsores. These surgeries cost the taxpayers in excess of $80,000. How ironic that she spent in excess of $3,000 of her own money for a bedsore that cost this resident her independence for life. To this day she describes the nursing home as a ***dungeon***.

In my opinion the MDS is the most informative and helpful assessment tool available to the nursing facility. It is a federally mandated assessment tool, implemented by Congress in 1987. The reason for creating this critical assessment tool was valid when first enacted and it is valid today. It must be enforced!

There is no question that many of these questionable activities were carried out to ensure financial gain for the facility. For example, for residents who enter a long term care facility funded by MediCal, the criterion for the amount of MediCal funding is determined by several factors. Cognitive patterns, i.e., their ability to recall, short and long term memory and physical functioning, i.e., body control problems and ambulation, represent two areas most likely to trigger the highest funding level.

On the MDS assessment a certain code will indicate that the resident is at the appropriate level of care. MediCal funding is limited to residents who have impairments in cognition and/or physical functioning. I was trained and instructed as an MDS coordinator to code every federally and state funded patient as having physical and cognitive impairments that did not reflect the patient's actual condition, but rather would ensure payment to the facility.

I realized the significance of the tampering of the paperwork only when a private pay patient who was paying in excess of $3,000 a month for care, ran out of private funding. She was informed that she needed to leave and find placement in a lesser level of care, because when her MDS was submitted with accurate information to MediCal for approval she was denied coverage because she did not meet federal and state funding guidelines.

Other types of patients are MediCare funded, such as those younger patients, who enter acute care hospitals after an unfortunate fall that leaves them with a hip or femur fracture. They require rehabilitative services, are sent to so-called "skilled" nursing facilities with intention of returning home soon. During the nursing home's initial admission assessment, the discharge planning goal for these residents is charted as *long term care*, in conflict with the patients', physicians' and families' goals to return home quickly. At the direction of my Director of Nursing, I frequently charted in this fashion.

MediCare Fraud

One very disturbing example of what in my opinion amounts to MediCare fraud involved a naso-gastric tube patient who was terminal from a massive cerebral vascular accident. She had 100 days of MediCare coverage because she had a naso-gastric tube inserted for nutritional support. During a care conference with the family, they requested to withdraw feeding because of the permanent irreversible damage to their mother. In the patient's advance directive her wishes were that her life not be sustained by artificial means, such as a feeding tube. I went to the Admissions Coordinator and was told this patient had 31 days left of MediCare, so we should wait until her MediCare funding was over. The wishes of the patient and her family were denied as a result of this calculated maneuver on the part of the nursing

home administration. .

I would hope that the Senators in audience today will not be quick to judge these employees of long term care facilities. Like myself they may believe they are one of the few lights in the darkness, or may have been manipulated into believing there are limited funds available to the residents. In one extreme case, a plea came from the owner in a staff meeting to convince the staff that funding was so poor that as a dedicated and caring owner, he had to take out a second mortgage on one of his million dollar homes to make payroll! He was lying and deceiving the staff as revealed during trial testimony. These same underpaid caregivers are at times your family's only access to a fresh bar of soap, shampoo and love not provided by the facility. They use their own money to buy diapers, soap, shampoo and even clothing for the residents, when in fact, the monthly gross income from MediCare and MediCaid billings alone were hundreds of thousands of dollars a month.

Conclusion

In conclusion of this difficult testimony, I would like to thank you Senator Grassley and Members of the Committee for having this heart-wrenching and yet terribly overdue investigation and hearing. I would challenge each of you to remember our elderly and protect the rights of forgotten, silent, and perhaps non-voting contributors of our society. It is my belief that we would never tolerate these conditions in nurseries and day care centers care for our children. We must object to this horrific mistreatment of our parents and grandparents.